

MDR Tracking Number: M5-04-3133-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 5-19-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Ambien, Cyclobenzaprin, Hydro/Apap and Celebrex, were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-25-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Neither the carrier nor the requestor provided EOB's for date of service 5-23-03. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). Per Rule 134.503 the reimbursement methodology for determining the MAR for Celebrex is as follows: \$2.88 (AWP per unit) x 60 = 172.77 x 1.09 = \$188.32 + \$4.00 = \$192.32. **Recommend reimbursement of \$192.32.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003; plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for date of service 5-23-03 as outlined above in this dispute.

This Decision and Order is hereby issued this 9th day of March , 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

October 28, 2004

**Amended Letter 03/01/05**

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-04-3133-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Orthopedic Surgery which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1983. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient sustained a work-related injury on \_\_\_\_\_. It appears that the patient underwent a previous lumbar fusion and is now diagnosed with Lumbar post fusion with pseudoarthrosis and chronic pain syndrome. The treating physician has prescribed Vicodin (hydrocodone/apap 5/50mg), Celebrex, cyclobenzaprin, and Ambien.

### Requested Service(s)

- Ambien, cyclobenzaprin, and hydrocodone/apap on 05/23/2003
- Celebrex, cyclobenzaprin, and Ambien on 09/15/2003
- hydrocodone/apap 10/16/2003
- Ambien, cyclobenzaprin, and hydrocodone/apap on 11/14/2003

### Decision

It is determined that there is no medical necessity for the medications in question to treat this patient's medical condition.

### Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the medications in question. These medications have been sporadically used over a six-month period of time. Prescriptions for Celebrex, Ambien, cylobenzaprin and hydrocodone/apap were written on 05/23/03, which appears to be a one-month supply. Then four months later another one month supply was given followed by another one month supply two months later. This is not consistent with severe continual pain. Therefore, the Celebrex, Ambien, cylobenzaprin and hydrocodone/apap for the dates of service in question were not medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment  
GBS:vn

### **Attachment**

#### **Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #:** M5-04-3133-01

#### **Information Submitted by Requestor:**

- Letter of Medical Necessity from South Texas Spinal dated 06/08/2004
- Letter of Medical Necessity from South Texas Spinal dated 01/16/2004
- Letter of Medical Necessity from South Texas Spinal dated 03/28/2003

#### **Information Submitted by Respondent:**

None